

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 24/84

Primary Registration District No. 4194

Registrar's No.

STATE FILE NUMBER 0030994

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0380

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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Gentry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Harrison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Albany		Length of stay in 1b 14 weeks	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gentry County Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Edgar Wilson		4. DATE OF DEATH Month Day Year Aug. 20, 1964	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/4/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Own)		10b. KIND OF BUSINESS OR INDUSTRY Farmer Rtd.	
13a. FATHER'S NAME Newton H. Wilson		13b. MOTHER'S MAIDEN NAME Matilda J. Ragan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		17. INFORMANT Address Mr. Pearl Wilson Denver, Mo. R.F.D.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 months	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1962 to 8/20/64 and last saw her/him alive on 8/20/62 Death occurred at 11:47 PM m on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS Albany Mo.	
22a. SIGNATURE Demie Parsons MD		22c. DATE SIGNED 8/22/64	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/22/64	23c. NAME OF CEMETERY OR CREMATORY Koger Cemetery	
24. FUNERAL DIRECTOR C.R. Noble		25. DATE RECD. BY LOCAL REG. 8-22-64	
26. REGISTRAR'S SIGNATURE Mr. A. W. Bare		27. LOCATION (City, town, or county) Worth County Mo.	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

Permit obtained - 8-28-68

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William George Noble

Licensed Embalmer No. 4987

P. O. Address Bethany, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.